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Nos. 02-1845, 03-83

IN THE

Supreme Court of the United States

AETNA HEALTH, INC.,

Petitioner,

v.

JUAN DAVILA,

Respondent.

CIGNA HEALTHCARE OF TEXAS, INC. AND CIGNA CORPORATION,

Petitioners,

v.

RUBY R. CALAD,

Respondent.

On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF FOR THE CHAMBER OF COMMERCE OF THE UNITED STATES AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether § 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a), completely preempts a state-law tort claim seeking damages for an allegedly erroneous determination of entitlement to a benefit under an ERISA-governed health benefit plan when the determination is based in part on the exercise of medical judgment?

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The Chamber of Commerce of the United States (the "Chamber") respectfully submits this brief pursuant to Supreme Court Rule 37.4 in support of Petitioners in both *Aetna Health Inc. v. Davila*, No. 02-1845 (granted Nov. 3, 2003), and *CIGNA HealthCare v. Calad*, No. 03-83 (granted Nov. 3, 2003).[1] The Chamber urges the Court to reverse the judgment of the United States Court of Appeals for the Fifth Circuit and hold that the Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code §§ 88.001-88.003, as applied in these cases, is preempted by § 502(a) of ERISA.

INTEREST OF *AMICUS CURIAE*

The Chamber is the world's largest business federation. It represents an underlying membership of more than three million businesses and organizations in every industrial sector and geographic region of the county. A principal function of the Chamber is to represent the interests of its members by filing *amicus* briefs in cases involving issues of vital concern to the nation's business community. In this regard, many Chamber members provide health benefits to employees and arrange for the provision of health care services through employee welfare benefit plans falling within the scope of ERISA. The ability of its members to purchase affordable health care coverage for the benefit of their employees is thus of vital importance to its members, their employees, the employees' dependents, and the Chamber.

In addition, the Chamber is concerned about the adverse effect that the imposition of myriad different and sometimes inconsistent state and federal obligations has on its members in regulated industries. The Chamber accordingly has filed numerous *amicus* briefs in this Court on the subject of federal

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[1] Pursuant to Supreme Court Rule 37.6, *amicus* states that no counsel for a party authored this brief in whole or in part, and no person or entity other than the Chamber has made a monetary contribution to the preparation or submission of this brief. All parties have consented to the filing of this *amicus* brief, and their consent letters are on file with the Clerk's Office.

preemption, including preemption under ERISA. *See, e.g.*, *Pegram v. Herdrich*, 530 U.S. 211 (2000); *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219 (1995); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

SUMMARY OF ARGUMENT

In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 52 (1987) ("*Pilot Life*"), this Court unanimously held that ERISA § 502(a) was intended to be the "exclusive" vehicle for challenging a determination of a "claim for benefits," and that state laws seeking to expand § 502(a)'s remedies are "completely preempted" by ERISA—that is, the complaint is deemed to raise a federal question for jurisdictional purposes and is also substantively preempted. Since *Pilot Life*, the Court has repeatedly reaffirmed these basic legal principles. *See, e.g.*, *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987) ("[A] suit by a beneficiary to recover benefits from a covered plan ... falls directly under § 502(a)(1)(b) of ERISA, which provides an exclusive federal cause of action for resolution of such disputes."); *Ingersoll-Rand*, 498 U.S. at 145 ("Not only is § 502(a) the exclusive remedy for vindicating [ERISA]-protected rights, but there is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek 'pension benefits.'"); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002) (observing that complete preemption applies where "state law duplicat[es] the elements of a claim available under ERISA" and "convert[s] the remedy from an equitable one . . . into a legal one."); *Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058, 2062-63 (2003) (relying on these cases to reaffirm the "complete preemption" doctrine).

In light of these long-standing principles accepted in *Pilot Life*, the Fifth Circuit plainly erred when it concluded that the THCLA is not completely preempted as applied here. Under the Texas statute, an ERISA-plan participant can seek damages for an erroneous health benefit determination when the

determination is based in part on the exercise of medical judgment. *See* Tex. Civ. Prac. & Rem. Code § 88.002. ERISA § 502(a)(1)(B), however, provides a remedy for improper benefits determinations, including determinations based on medical judgment, and the ERISA remedy does not include the legal damages that Texas law allows. *See* 29 U.S.C. § 1132(a)(1)(B). *Pilot Life* thus compels the conclusion that the THCLA is completely preempted.

There is, moreover, no persuasive justification for departing from the long-standing rule that state-law causes of action challenging alleged erroneous benefit determinations are completely preempted. In the sixteen years since the interpretation of ERISA § 502 was settled in *Pilot Life*, employers and health benefit plan sponsors have relied on this Court's preemption decisions when designing benefit plans. Indeed, virtually every health benefits plan in the country—not only those run by HMOs but also traditional fee-for-service plans—limits treatment to only "medically necessary" procedures and excludes "experimental" procedures. When including these discretionary-judgment provisions in their health plans, employers justifiably assumed that state-law challenges to a plan's administration would be preempted. Changing or abandoning that statutory precedent now would unfairly expose plan sponsors to potentially massive, retroactive financial liabilities in all 50 States.

Nothing since the enactment of ERISA or the issuance of *Pilot Life* counsels in favor of altering this Court's preemption jurisprudence and thereby undermining these justifiable reliance interests of plan sponsors in the Court's interpretation of ERISA § 502. Certainly, the mere existence of HMOs and their practice of utilization review are not new phenomena that justify a change in statutory precedent. Nor are legal remedies necessary to redress some perceived economic imbalance between HMOs—which are only a subset of employee benefit plans—and health benefit plan participants. Employers and plan sponsors, who ultimately pay for health plans, exercise

significant market power over HMOs and other managed care organizations. As a result, employers can, and do, ensure that health plans provide the benefits for which they contracted and opt out of health plans administered improperly. Numerous legal safeguards also protect against arbitrary acts by benefits administrators. For example, plan participants who believe they have been wrongly denied coverage can seek independent review under state insurance laws and/or seek injunctive relief under ERISA.

This Court should not alter these traditional preemption principles out of concern for the States' interest in regulating the practice of medicine. Doing so would substantially increase the cost of health care coverage and reduce the availability of affordable health insurance nationwide, contrary to ERISA's purposes. Benefits determinations—even those involving medical judgment—are not, moreover, medical treatment decisions, as principles of contract interpretation and Department of Labor regulations well demonstrate. States have sufficient authority to regulate the practice of medicine and the conduct of treating physicians. In addition, they can require independent review of benefit determinations by insured plans and, if they desire, mandate the provision of benefits by insured plans. What States cannot do is impose tort liability on the basis of a benefits determination. To the extent there is any doubt on this score, case law under § 301 of the Labor-Relations Management Relations Act ("LMRA")—which served as the model for § 502 of ERISA—makes clear beyond peradventure that the claims here are preempted.

ARGUMENT

I. THIS COURT'S PRIOR DECISIONS BAR STATES FROM CREATING TORT ACTIONS FOR IMPROPER BENEFITS DETERMINATIONS.

A. Numerous Cases Establish That State Law Claims Challenging Benefits Determinations—Even Ones That Involve Medical Judgment—Are Completely Preempted Under ERISA § 502(a).

It is well established that ERISA § 502(a) provides the exclusive remedy for violations of the rights and benefits guaranteed under ERISA. The Court first recognized the exclusivity of § 502(a) sixteen years ago in *Pilot Life*.

In that case, an employee sued Pilot Life Insurance for breach of contract, breach of fiduciary duty and fraud in the inducement after Pilot Life repeatedly terminated and reinstated the employee's disability benefits. In an opinion authored by Justice O'Connor, the Court unanimously concluded that state law actions challenging allegedly improper benefits determinations are completely preempted by ERISA. The Court reasoned that "[t]he conclusion that § 502(a) was intended to be exclusive" is demonstrated "by the language and structure of the civil enforcement provisions," as well as by its legislative history. *Pilot Life*, 481 U.S. at 52.

With respect to ERISA's language, the Court observed:

> the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Id. at 54. With respect to the legislative history, the Court found that it "fully confirmed" this reading of § 502(a). *Id.* The Court noted that the Conference Report described § 502(a) as "in similar fashion" to § 301 of the LMRA, which the Court characterized as an act with "powerful pre-emptive force" that displaced "all state actions for violation of contracts between an employer and a labor organization, even when the state action purport[s] to authorize a remedy unavailable under the federal provision." *Id.* at 54-55 (internal quotations and citation omitted).

Since *Pilot Life*, this Court has repeatedly reaffirmed that § 502(a) of ERISA is the exclusive vehicle for any challenge to a benefits determination and defines exclusive remedies for claims covered by ERISA. In *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987), the Court unanimously concluded that an employee could not sue under state law for an employer's failure to pay disability benefits; Congress had so completely preempted this area "that any civil complaint raising this select group of claims [within the scope of ERISA] is necessarily federal in character." *Id.* at 63-64. Similarly, in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), an employee sued his employer for wrongful discharge under state law, claiming that his employer terminated him to avoid paying pension benefits. *Id.* at 136-37. The Court unanimously held that the wrongful discharge action was preempted because the underlying complaint fell within the "ambit of ERISA['s]" substantive provisions. *Id.* at 142. In *Rush Prudential v. Moran*, 536 U.S. 355, 379 (2002), although the Court found that state utilization review statutes are not preempted, it observed that state laws are "incompatible with ERISA's enforcement scheme" and preempted if they "provid[e] a form of ultimate relief in a judicial forum that add[s] to the judicial remedies provided by ERISA." *Id.* at 379. Most recently, in *Beneficial National Bank v. Anderson*, 123 S. Ct. 2058, 2062-63 (2003), this Court relied on *Pilot Life* and its progeny to reaffirm the "complete preemption" doctrine.

B. The Fifth Circuit's Analysis Is Erroneous.

In light of this precedent, the Fifth Circuit plainly erred in holding that the THCLA is not completely preempted by ERISA § 502. Under § 502(a)(1)(B), "a participant or beneficiary" of an employee benefits plan is entitled "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Whether the benefits determination involves some medical judgment is irrelevant to this ERISA remedy, as § 502(a)(1)(B) applies regardless of the kind of factors relied upon by the plan in making a benefits determination. *See, e.g., Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1968-71 (2003) (considering claim for disability benefits where benefits denied allegedly due to improper medical determination). Department of Labor regulations confirm that the presence of some medical judgment does not convert a benefits determination into a medical treatment decision; it remains a "benefits determination that is based in whole or in part on a medical judgment." 29 C.F.R. § 2560-503-1(h)(3)(iii).

Because this § 502(a) remedy is exclusive, the State of Texas cannot supplement or restrict the ERISA remedy. That, however, is precisely the THCLA's function. It provides plan participants a new damages remedy whenever an HMO erroneously denies coverage due to some mistake in medical judgment. *See* Tex. Civ. Prac. & Rem. Code § 88.002. As such, the THCLA is completely preempted under *Pilot Life* and its progeny.

In reaching the contrary conclusion, the Fifth Circuit committed several errors. *See Roark v. Humana, Inc.*, 307 F.3d 298 (5th Cir. 2002). As an initial matter, the Fifth Circuit all but ignored *Ingersoll-Rand*, which reaffirmed the core holding in *Pilot Life* that state law cannot provide a remedy for conduct that is covered by § 502(a). In addition, the Fifth

Circuit wrongly departed from *Pilot Life* based on an erroneous reading of this Court's decision in *Rush Prudential*.

In the Fifth Circuit's view, *Rush Prudential* held that "*Pilot Life*'s rule is a narrow one: States may not *duplicate* the causes of action listed in ERISA § 502(a)." *Roark*, 307 F.3d at 310-11 (emphasis supplied). *Pilot Life* itself, however, rejected this narrow approach to preemption, holding instead that "*all suits* brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § 502(a)." 481 U.S. at 56 (emphasis supplied). Indeed, the plaintiff in *Pilot Life* pursued claims such as emotional distress that did not have exactly the same elements as a § 502(a) claim. The Court nonetheless held these claims preempted, because they all arose from the same event governed by ERISA—the determination of benefit eligibility.

Far from revisiting *Pilot Life*, *Rush Prudential* confirmed that state law is preempted whenever it supplements an ERISA remedy, because state law cannot "expan[d] the potential scope of ultimate liability imposed upon employers by the ERISA scheme." *Rush Prudential*, 536 U.S. at 379. The supposedly "limiting" language from *Rush Prudential* that the Fifth Circuit cites—ERISA exclusivity applies when a state law "*duplicate*[*s*] the elements of a claim available under ERISA," *id.* (emphasis supplied)—does not signal a departure from *Pilot Life*. The Court was not there requiring an identity of every element of a state law and the § 502(a) remedy for preemption to apply. It was merely observing that, where ERISA provides a remedy for some underlying wrong, state law cannot add to that remedy. *Id.* The Fifth Circuit's effort to read more into *Rush* is untenable.

C. The Contrary Analysis Of Other Courts Of Appeals Is Also Similarly Unpersuasive.

Although not part of the Fifth Circuit's analysis, the Second Circuit has suggested that state-law actions challenging allegedly erroneous medically-based eligibility determinations are not preempted because *Pegram v. Herdrich*, 530 U.S. 211 (2000) ("*Pegram*"), "alters the framework" of ERISA preemption. *See Cicio v. Does*, 321 F.3d 83, 102 (2d Cir. 2003). In the Second Circuit's view, *Pegram* teaches that distinguishing between medical care and benefits administration "is no longer tenable" and "demonstrates that the mere presence of an administrative component in a health care decision no longer has determinative significance for purposes of preemption analysis when the decision also has a medical component." *Id.* at 102, 103. *Pegram* cannot properly be read to so alter *Pilot Life*.

Pegram concerned whether an HMO could be held liable for breach of fiduciary duty, *see* 29 U.S.C. § 1109(a), where a single physician providing medical treatment acts both as the plaintiff's treating physician and as administrator of an HMO. In that case, the physician allegedly delayed necessary treatment to maximize the HMO's financial gain, and the plaintiff suffered a serious physical injury as a result. *See Pegram*, 530 U.S. at 216-17. The Court concluded that "Congress did not intend [the physician] or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians." *Id.* at 231.

Pegram clearly did not alter the framework of § 502(a) preemption established by *Pilot Life* and its progeny. In *Pegram*, the plaintiff did not contend that the HMO or physician rendered an improper benefits determination, but argued only that the HMO had violated its fiduciary duty by failing "to act solely in the interest of beneficiaries." *Pegram*, 530 U.S. at 226; *see also id.* at 229 n.9. Moreover, the Court concluded only that an HMO does not act as a fiduciary under ERISA when a single

physician treats patients and administers an HMO. *Id.* at 236-37. While the Court noted that its conclusion helped avoid "a puzzling issue of preemption," the Court expressly declined to decide *any* ERISA preemption question. *Id.* at 229 n.9 (observing that Court had "no occasion to discuss the standards governing" a § 502(a)(1)(B) claim or "the interaction of such a claim with state-law causes of action"). Thus, *Pegram* cannot conceivably stand as doctrinal authority for a departure from *Pilot Life* and its progeny.

Nor is the preemption issue that concerned the Court in *Pegram* even implicated by the kind of state law causes of action saved by the Fifth Circuit below and the Second Circuit in *Cicio*. In *Pegram*, because a single physician was both the treating physician and the HMO administrator, it could be argued that the physician and his employer, the HMO, were providing medical services and should arguably be subject to state malpractice claims for alleged erroneous treatment decisions. *Pegram*, 530 U.S. at 236-37. But this argument is inapposite where the benefits plan administrator is not the treating physician at all. In these circumstances, the plan is clearly making only benefits determinations, not treatment decisions, and thus is plainly subject to the exclusive province of § 502(a) of ERISA.

D. There Has Been No "Retrenchment" From § 502 Preemption Principles.

In addition to erroneously interpreting *Pegram*, the Second Circuit suggested that this Court has "tempered" its preemption analysis and that "the criteria set forth in early cases like *Shaw* and its progeny have in effect been abandoned." *Cicio*, 321 F.3d at 99 (quoting *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr. N.A.*, 519 U.S. 316, 335 (1997) (Scalia, J., concurring)). But the Court's reconsideration of its ERISA § 514 jurisprudence is irrelevant here: as Judge Calabresi pointed out in his dissent, *see Cicio*, 321 F.3d at 108, and as the Second Circuit inconsistently acknowledged, *id.* at 99-100, this

Court has not retrenched at all from the basic principle that § 502 preempts suits seeking relief for an erroneous benefits determination.

II. THERE IS NO PERSUASIVE JUSTIFICATION FOR ABANDONING *PILOT LIFE*.

The real issue here is thus not whether *Pilot Life* and its progeny answer the question presented, but whether the Court should abandon or revise this otherwise controlling precedent. That question must be answered by reference to the decisional principles governing *stare decisis*, and those principles counsel decisively against altering *Pilot Life* and its progeny.

A. *Stare Decisis* Principles.

This Court has repeatedly recognized that "any departure from the doctrine of *stare decisis* demands special justification." *Arizona v. Rumsey*, 467 U.S. 203, 212 (1984). Indeed, because the principle of *stare decisis* has "special force in the area of statutory interpretation," *Patterson v. McLean Credit Union*, 491 U.S. 164, 173 (1988), altering the rule of law in a case such as this one demands some additional basis for overcoming the strong "presumption of adherence" to cases interpreting statutes. *Ill. Brick Co. v. Illinois*, 431 U.S. 720, 736 (1977); *Hilton v. S.C. Pub. Rys. Comm'n*, 502 U.S. 197, 205 (1991) (*Stare decisis* is most compelling where "a pure question of statutory construction is involved."). In considering whether to revisit existing precedent, the Court considers whether "there has been reliance on the decision" such that "to disturb it now would be fraught with many injurious results." *United States v. Title Ins. & Trust Co.*, 265 U.S. 472, 486 (1924). *See also Dickerson v. United States*, 530 U.S. 428, 443 (2000) (declining to overrule *Miranda*). The Court also reviews whether the factual or legal landscape has so changed since its earlier decision as to rob it of justification or workability. *See, e.g., Burnet v. Coronado Oil & Gas Co.*, 285 U.S. 393, 412 (1932) (Brandeis, J., dissenting); *Planned Parenthood of S.E. Pa. v. Casey*, 505

U.S. 833, 854-55 (1992). Mere asserted error in a prior decision or a change in Court personnel—such that a new majority would decide the question differently if it were being presented as a matter of first impression—are insufficient grounds for departing from prior decisions of the Court. *Accord*, *Patterson*, 491 U.S. at 171-75.

B. There Is No Special Justification For Abandoning Or Revising *Pilot Life*.

The Court's *stare decisis* principles in statutory interpretation cases counsel strongly against abandoning or revising *Pilot Life* and its progeny. Indeed, fairly applied, they foreclose any such effort.

1. Plan Sponsors And Participants Have A Strong Reliance Interest In Existing Precedent.

As an initial matter, revising *Pilot Life*'s interpretation of ERISA's exclusivity rule would injure employee benefit plan sponsors who have relied on *Pilot Life* and its progeny over the past sixteen years to develop their health benefit plans.

Today, virtually every health benefits plan in the country—regardless of whether the plan is administered by an HMO, an employer, or a traditional fee-for-service provider—limits coverage to those recommended treatments that are "medically necessary" and excludes "experimental treatments," the kinds of medically-based coverage determinations at issue here. *See* R. Rosenblatt, *et al.*, LAW & THE AMERICAN HEALTH CARE SYSTEM 19, 211-15 (1997). When including these discretionary-judgment provisions in their plans, plan sponsors understandably relied on *Pilot Life* and its progeny and assumed that any erroneous coverage determination, including improper determinations involving medical judgment, would be subject only to a § 502(a) claim and remedy. Given the now near universality of medical necessity and experimental treatment provisions in benefits plans, judicially altering the complete preemption doctrine at

this point would be patently unfair to plan sponsors and the administrators of their health benefit plans. Absent preemption, nearly every benefits plan in the country—regardless of whether they are HMO or fee-for-service plans—could be subject to retroactive malpractice challenges and possible liability under the different laws of 50 States.

The potential financial injury here for plan sponsors and their administrators far outweighs the more limited economic harms that this Court in the past has held sufficient to require adherence to *stare decisis*. In *United States v. Title Ins. & Trust Co.*, 265 U.S. at 486, for example, the Court refused to revise 23-year-old precedent concerning a land grant in Southern California, because the decision "affected many tracts of land in California," and numerous property purchases had been made in reliance on it. And, in *NLRB v. Int'l Longshoreman's Ass'n, AFL-CIO*, 473 U.S. 61, 84 (1985), the Court refused to revisit its decisions on the work-preservation doctrine because "management and labor alike have relied on the work preservation doctrine to guide their [collective] bargaining." Here, in contrast to these limited but nonetheless decisive reliance interests, abandoning *Pilot Life* would expose nearly every health benefits plan administrator and plan sponsor in the country—including roughly 66% of all employers in the United States—to potentially massive, previously unforseen and heretofore precluded liabilities. *See* Kaiser Family Foundation & Health Research & Educational Trust, EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY 4 (2003) ("Kaiser Study") (observing that 66% of all employers offer health coverage to their workers).

Indeed, altering the exclusivity rule at this late date would undermine the basic policy motivating ERISA preemption. As this Court has explained, the purpose of complete preemption is to "induc[e] employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush*

Prudential, 536 U.S. at 379. Congress, too, expressly recognized that preemption was intended to create a "uniformity of decision" on which plan sponsors could rely "to predict the legality of proposed actions without the necessity of reference to varying state laws." S. Rep. No. 93-127, at 29 (1973), *reprinted in* 1 Legislative History of the Employee Retirement Income Security Act of 1974, at 615 (Comm. Print 1976) ("ERISA Leg. Hist."). But altering ERISA's exclusivity rule would transform what were "predictable liabilities" into a morass of potential unforeseen liabilities in all 50 States. *See also Pilot Life*, 481 U.S. at 56 (noting that "[t]he expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop . . . would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws").

2. Developments Since *Pilot Life* Was Decided Do Not Justify A Change In Preemption Principles.

Moreover, there has been no shift in the factual or legal landscape since *Pilot Life* was decided that would justify such damage to the reliance interests of employers, plan sponsors and plan administrators. To be sure, in *dicta* and non-binding opinions, some have suggested (i) that the rise of managed health care and "prospective utilization review" were "unforseen at the time of ERISA's enactment," *Cicio*, 321 F.3d at 98; (ii) that HMOs have an "incentive" to "mistreat [plan] beneficiaries," *DiFelice v. Aetna U.S. HealthCare*, 346 F.3d 442, 454 (3d Cir. 2003) (Becker, J., concurring), and "ignore the individual needs of a patient in order to improve the HMO's bottom lines," *Pegram*, 530 U.S. at 220 (describing arguments of critics of HMOs); (iii) that HMOs now exercise ultimate control over medical treatment because "coverage decisions based on medical determinations often have an outcome-determinative effect," *Cicio*, 321 F.3d at 102; and (iv) that, due to the confluence of this Court's decisions, the remedies that ERISA provides "do[] not 'make whole' plan beneficiaries

harmed by plan administrators' misconduct," *id.* at 107 (Calabresi, J., dissenting). But, to the extent that these arguments focus on traditional HMOs and HMO practices, they fail to recognize that state-law tort actions of the type in issue could apply well beyond HMOs—to, *e.g.*, PPOs and self-insured plans that also deny coverage on the basis of medical judgments. Indeed, given that traditional HMOs provide a declining and minority share of health care today, *see* Kaiser Study at 6, broadly changing ERISA preemption to address perceived problems in such HMOs alone would truly sacrifice the baby to change the bath water. In any event, the arguments are themselves either just outright wrong or in all events plainly insufficient to justify abandonment of the well-settled interpretation of statutory preemption in *Pilot Life* and its progeny.

a. Congress Was Aware Of HMOs And Their Practice Of Utilization Review When It Passed ERISA.

First, the claim that managed health care and its attributes were unforseen by Congress when it passed ERISA, *see Cicio*, 321 F.3d at 98, 102, is simply incorrect. Managed care organizations, like HMOs, are not recent phenomena at all, *see* Employee Benefit Research Institute, FUNDAMENTALS OF EMPLOYEE BENEFIT PROGRAMS 193 (1987) ("EBRI"), and were well-established at the time of *Pilot Life*. "Although it is often thought that health maintenance organizations were a product of the 1970s, some HMOs were among the earliest providers of medical expense coverage." B. Beam & J. McFadden, EMPLOYEE BENEFITS 191 (6th ed. 2001). The Kaiser Plans, for example, date back to the 1930s. *Id.*

Congress's awareness of HMOs and utilization review procedures at the time of ERISA's passage, moreover, is well documented. In the year prior to ERISA's passage, Congress passed the Health Maintenance Organization Act of 1973 ("HMO Act"), Pub. Law No. 93-222, 87 Stat. 914 (1973)

(codified at 42 U.S.C. § 300e-14a), a "significant piece of legislation" that "sought to encourage the growth of HMOs by providing funding for their development costs and mandating that certain employers make these plans available to employees." Beam & McFadden, *supra*, at 193. As this Court recognized in *Rush Prudential*, 536 U.S. at 369, "one year before it passed ERISA, Congress itself defined HMOs in part by reference to risk, set minimum standards for managing the risk, showed awareness that States regulated HMOs as insurers and compared HMOs to indemnity or service benefits insurance plans" (internal quotation omitted).

Indeed, Congress "conducted an intensive set of public hearings in respect to HMO legislation, [dating] back to July, 1971." S. Rep. No. 93-129, *reprinted in* 1973 U.S.C.C.A.N. 3033, 3037 (1973). One Senate subcommittee itself alone conducted "extensive hearings for a period lasting over three weeks" about HMOs and heard from "witnesses represent[ing] a wide range of interests, both private and public, rural and urban, provider and consumer, and came from all regions of this country." *Id.* Contrary to the erroneous assertion that Congress simply could not have foreseen modern complaints about prospective utilization review, during these pre-ERISA hearings, this Senate subcommittee heard testimony "largely from physicians" who feared that they would be told "how to practice medicine" as a result of the HMO Act. *Id.* at 3038.

Prior to the enactment of ERISA, Congress was also demonstrably well aware of utilization review procedures. In that time-frame, Congress considered amendments to the Social Security Act that sought to emulate HMOs' cost-containment strategies by adding utilization review procedures to benefit determinations in Medicaid, Medicare and other federally-funded health programs. *See* H.R. Conf. Rep. No. 92-1605, *reprinted in* 1972 U.S.C.C.A.N. 5370, 5378 (1972) (discussing proposed amendment that required States to establish "an effective utilization review program"); *id.* at 5383 (observing that House would have authorized agency "to experiment" with

"utilization review and medical review mechanisms" but Senate rejected proposal); H.R. Conf. Rep. No. 90-1030, *reprinted in* 1967 U.S.C.C.A.N. 3179, 3192 (1967) (discussing Senate amendment to Social Security Act requiring utilization review by hospitals). Indeed, in *Pegram*, this Court held that ERISA's fiduciary duty rules were inapplicable to single physicians acting as both HMO administrators and treating physicians precisely because, in enacting ERISA, Congress did not intend to discourage HMO formation and utilization review efforts. *Pegram*, 530 U.S. at 233-34.

In short, it is factually wrong to suggest that Congress was unaware of managed care and utilization review when it passed ERISA. It had long studied HMOs, was aware of the criticism that they had the potential to influence medical treatment, but nonetheless encouraged their development as a low-cost health care alternative and sought to base federally-funded health programs, in part, on their utilization review model. S. Leimberg & J. McFadden, THE TOOLS & TECHNIQUES OF EMPLOYEE BENEFIT & RETIREMENT PLANNING 264 (2d ed. 1990) ("Congress enacted the Health Maintenance Organization Act of 1973 to encourage HMOs as a way of keeping down health care costs."). Moreover, to the extent that HMOs were in their infancy when Congress passed ERISA, ERISA had the effect of causing HMOs and the health care industry to structure themselves in a certain way—including designing plans that contain "medical necessity" and "experimental" treatment provisions. *See* Beam & McFadden, *supra*, at 193. These structures were well-established by the time of *Pilot Life*. Altering *Pilot Life* now would thus harm the industry's reliance on the opportunities for development that Congress provided, not address an unforeseen change in facts. *Stare decisis* principles governing statutory precedent thus compel adherence to, not a departure from, extant ERISA preemption jurisprudence.

b. Numerous Market And Legal Safeguards Prevent Arbitrary Or Abusive Practices By Benefits Administrators.

Second, HMOs and other health benefits plans cannot systematically mistreat plan participants. Numerous market and legal safeguards prevent arbitrary or abusive practices by benefits administrators.

Importantly, employers are the primary source of health insurance in the United States, as "[e]mployer-sponsored health benefits reach nearly three out of every five Americans." Kaiser Study at 1. The employer or plan sponsor, *not the insurance company or the HMO*, determines the kind of health care plans that plan participants will be offered—*e.g.*, HMOs, PPOs, traditional fee-for-service plans. *See* EBRI, *supra*, at 176-79. Moreover, they determine the kinds of medical services that will be covered, who will be eligible to participate in health benefits plans, and the amounts that employees will be required to contribute to the cost of their health care through payroll contribution payments, office visit co-payments and deductibles. *Id.* at 178-79. It is thus the plan sponsor, not the insurance company or the HMO, who establishes, for example, the "medical necessity" and/or "experimental" treatment provision in a plan; and it is the plan sponsor's intent—not the insurance company's intent or the HMO's intent—that determines whether those provisions apply in particular circumstances. *See generally* Leimberg & McFadden, *supra*, at 255-57 (detailing how plan sponsors formulate health benefit plans); J. Meyer, *et al.*, ASSESSING BUSINESS ATTITUDES ON HEALTH CARE 6 (Oct. 1996), *reprinted at* www.eresearch.org/Documents/Attitudes.pdf (explaining that employers shift to different kinds of health providers as method of cost containment); P. Sheedy & S. Lawson Cann, *Contain Rising Health Care Costs With Strategy & Education*, 6 WOMEN'S BUSINESS BOSTON, at 7 (Issue 2 Nov. 2003) (describing ways in which employers can alter health benefit plans to control costs).

Because employers contract for insurance coverage, and because these plan sponsors both want the benefit of their bargain and control whether an insurance company or HMO will get business in the future, they exercise significant legal and market power over HMOs and insurers and provide a major check on potential abusive practices by plan administrators. If an HMO, for example, were routinely and improperly to deny coverage (by, for example, construing "medical necessity" and/or "experimental" treatment provisions in an inappropriate or stingy way), the employer could amend the plan to prevent continuing denials, and/or it could switch its health benefit plans to different, more responsible operators. Thus, in the 1990s, many employers shifted away from traditional HMO provider plans (to PPOs and other managed care entities) in response to employee complaints about HMO service and care. *See* Kaiser Study at 6-8 (observing that employers even *offering* a *choice* of traditional HMO care had declined from 68% in 1993 to 47% in 2003). And, last year, 62% of all employers exercised their market power over plan administrators by shopping around for alternatives to their current health benefits plans. *Id.* at 2. Accordingly, the idea that HMOs and insurers have no incentive but to harm plan participants and can improperly deny coverage without consequence blinks at important, and dominant, market realities.

In addition, numerous effective safeguards exist to prevent HMOs and other managed care organizations from arbitrarily mistreating individual plan participants. For example, if plan participants believe that their benefits administrator has made an erroneous coverage determination, they may immediately challenge that decision through ERISA's civil enforcement scheme or, alternatively, receive a declaration of coverage prior to treatment. *See, e.g.*, *Meditrust Fin. Serv. Corp. v. Sterling Chem., Inc.*, 168 F.3d 211, 213 (5th Cir. 1999); *Solger v. Wal-Mart Stores, Inc. Assocs. Health & Welfare Plan*, 144 F.3d 567, 568 (8th Cir. 1998); *Bernstein v. CapitalCare, Inc.*, 70 F.3d 783, 784-85 (4th Cir. 1995). Under ERISA, "[p]lans must provide an appeals procedure to participants whose claims are

partially or completely denied. The reason for claim denial must be provided in writing to the participant, and the participant must have the right to request a reconsideration of the decision. If the claim is denied again, the participant can file suit." EBRI, *supra*, at 35. ERISA plan participants can also receive immediate injunctive relief from federal courts under § 502(a) to enforce benefit provisions. *See Pryzbowski v. U.S. HealthCare, Inc.*, 245 F.3d 266, 273-74 (3d Cir. 2001). Indeed, "[t]here have been numerous cases in which courts have issued preliminary injunctions" to require an immediate benefits determination authorizing care. *Id.* (citing cases).

In these review proceedings, moreover, administrators are not free to arbitrarily interpret a benefits plan, but must implement the intent of the plan sponsor. In that regard, in the context of "medical necessity" and "experimental" treatment provisions, plan administrators are in fact and in law tethered to prevailing industry and community standards about medical care, because the terms "medical necessity" and "experimental treatment" have a customary meaning in the trade. *See* RESTATEMENT (SECOND) CONTRACTS § 202(3)(b) ("[T]echnical terms and words of art are given their technical meaning when used in a transaction within their technical field."). These objective interpretive standards guarantee that the appeals process contemplated by ERISA will protect individual plan participants from random and arbitrary eligibility determinations.

State insurance law provides a real safeguard against abuses by HMOs. As this Court has established, HMOs are subject to state insurance laws. *See Rush*, 536 U.S. at 366-70. Plan participants can also seek independent external review under state statues. Indeed, at least forty States and the District of Columbia have passed laws permitting plan participants to obtain an independent, external review of medical-necessity determinations. *See* Alaska Stat. § 21.07.050 (Michie 2001); Ariz. Rev. Stat. Ann. § 20-2537 (2000); Cal. Ins. Code § 10169 (2001); Colo. Rev. Stat. § 10-16-113.5 (2000); Conn. Gen. Stat.

§ 38a-478n (2001); 16 Del. Code Ann. § 9119 (2000); D.C. Code Ann. § 44.301.07 (2000); Fla. Stat. § 408-7056; Ga. Code Ann. § 33-20A-32 (2000); Haw. Rev. Stat. § 432E-6 (2000); 215 Ill. Comp. Stat. § 125/4-10 (2000); Ind. Ins. Code Ann. § 27-13-10.1-1 (2000); Iowa Code Ann. § 514J (2000); Kan. Stat. Ann. § 40-22a13 (2000); Ky. Rev. Stat. Ann. § 304.17A-623 (2001); La. Rev. Stat. Ann. § 22:3081 (2000); Me. Rev. Stat. tit. 24-A, § 4312 (2000); Md. Code Ann. Ins. § 15-10A-01 (2001); Mass. Gen. Laws Ann. ch. 1760 § 14 (2001); Mich. Comp. Laws § 550.1907 (2001); Minn. Stat. § 62Q.73 (2000); Mo. Rev. Stat. § 376.1385 (2000); Mont. Code Ann. § 33-37-102 (2000); N.H. Rev. Stat. Ann. § 420-J:5 (2000); N.J. Stat. Ann. § 26:2S-11 (2001); N.M. Adm. Code tit. 13, § 10.17.24 (2000); N.Y. Ins. Law § 4904 (McKinney 1999); N.C. Gen. Stat. § 58-50-62 (1999); Ohio Rev. Code Ann. § 1751.84 (Anderson 2001); Okla. Stat. tit. 63, § 2528.3 (2000); Or. Rev. Stat. § 743-857 (2001); 40 Pa. Cons. Stat. § 991.2162 (1998); R.I. Gen Laws § 23-17.12-10 (2001); S.C. Code Ann. § 38-71-1970 (2000); Tenn. Code Ann. § 56-32-227 (2001); Tex. Ins. Code § 21.58A (Vernon Supp. 2001); Utah Code Ann. § 31A-22-629 (2000); Vt. Stat. Ann. tit. 8, § 4089f (2001); Va. Code Ann. § 38.2-5901 *et seq.* (2001); Wash. Rev. Code § 48.43.535 (2001); W. Va. Code § 33-25C-6 (2001); Wis. Stat. § 632.835 (2000). In addition, many of these statutes contain expedited review procedures. In New York, for example, plan participants can receive expedited external review within three days of a benefits determination. *See Regulators: External Review Works For New York Consumers' Health Claims*, BEST'S INS. NEWS, 2003 WL 59121106 (Sept. 12, 2003).

To the extent that these market and other legal safeguards prove inadequate, the State always has available to it the ability to mandate the provision of specific benefits by insured plans. *See* 29 U.S.C. § 1144. The tort action authorized here and in other cases, however, is not an insurance law and, at least in some contexts, could extend well beyond the insurance

industry to include even self-insured plans. *See Pilot Life*, 481 U.S. at 51-53.

There is, in short, no pattern of abuse by HMOs that justifies abandonment of statutory precedent such as *Pilot Life*. On the contrary, market and legal safeguards have responded repeatedly and effectively to address concerns about HMO practices.

c. HMOs Do Not Control Medical Treatment Decisions.

Third, it is equally wrong to suggest that managed care organizations control medical treatment decisions. Those decisions are in fact made by the patient and the treating physician. Certainly nothing about these realities has changed since *Pilot Life* was decided.

Except where a treating physician and health benefits administrator are one and the same—in which case the physician will always be liable under state law for an erroneous treatment decision (and under ERISA for an erroneous benefits decision)—insurance companies and other health benefits administrators do not make medical treatment decisions. The benefits administrator does not recommend medical treatment or deny medical treatment. The benefits administrator simply determines whether the plan will pay for a particular treatment. It decides only "pre-certification benefit decisions on behalf of the plan." *Thompson v. Gencare Health Sys., Inc.*, 202 F.3d 1072, 1074 (8th Cir. 2000). "[The] patient and her treating physicians retai[n] ultimate decision-making authority regarding her medical care." *Id.* Any other view of benefits determinations involving medical judgment, indeed, would be inconsistent with Department of Labor regulations, which expressly treat "medical necessity" and other medically-based eligibility decisions as part of the benefits determination process. *See generally* 29 C.F.R. § 2650.503-1.

Individuals would no doubt prefer for all treatments to be covered by their health benefits plan. But, plans do not cover all treatments and, when coverage is denied, individuals remain free to pay for the treatment themselves and, if appropriate, sue under ERISA to recover any benefits improperly denied. Individuals commonly pay health care costs out of pocket and only later seek to recover their expenses. *See Thompson*, 202 F.3d at 1073; *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 56 (1st Cir. 1999); *Castillo v. Cigna Healthcare*, No. 00-15573, 2001 WL 638403, at *2 (9th Cir. June 7, 2001); *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 962 (7th Cir. 2000), *aff'd* 536 U.S. 355 (2002); *Bast v. Prudential Ins. Co. of Am.*, 150 F.3d 1003, 1005 (9th Cir. 1998). Moreover, charitable organizations and medical research facilities provide financial support and, sometimes, the care itself when coverage is denied for "experimental" treatments, for example. *See Community Garage Sale is Fund-Raiser for Slidell Child*, TIMES-PICAYUNE, 2003 WL 60073003 (Oct. 30, 2003) (charitable aid); L. Hugh, *Troops in Korea Help Grand Ledge Student*, LANSING STATE JRNL., 2003 WL 63333706 (Oct. 6, 2003) (same); *MMI AIDS Drug Showing Considerable Promise*, WMRC DAILY ANALYSIS, 2003 WL 63612472 (Oct. 7, 2003 (study).

The fact that medical treatment choices may be financially difficult, and a plan participant may be "perhaps unable or unwilling to undergo costly treatment not covered by the plan . . . does not mean [the] plan administrator control[s] her medical care." *Thompson*, 202 F.3d at 1074. Individuals "must sometimes choose a course of action within a limited context of relatively distasteful options" but that does not mean the choice is "compelled" or involuntary. *Cherchi v. Mobil Oil Corp.*, 693 F. Supp. 156, 163 (D.N.J), *aff'd*, 865 F.2d 249 (3d Cir. 1988) (internal quotations and citation omitted). The choice about treatment is still that of the patient and the doctor; the plan administrator only decides whether the plan will pay for their choice. Certainly, nothing about these realities has changed since *Pilot Life*, and accordingly,

complaints about HMO influence on medical treatment choices is not a basis for revisiting that statutory precedent.

d. Alteration of ERISA Preemption Jurisprudence Is Not An Appropriate Response.

Finally, altering ERISA preemption principles is not the proper response to any perceived gap in ERISA's remedial scheme. Judges Calabresi and Becker have opined that ERISA is failing because it provides no consequential damages remedy for improper coverage determinations. But, as even those judges admit, the argument that additional remedies are needed under ERISA is an argument for legislative action or reconsideration by this Court of its own consequential damages rulings, not for "stretching to avoid preemption in order to allow state actions for consequential damages." *Cicio*, 321 F.3d at 109 (Calabresi, J., dissenting); *see also*, *DiFelice*, 346 F.3d at 465-66 (Becker, J., concurring) (suggesting potential legislative solutions to provide additional compensation for individuals who are improperly denied medical coverage). Indeed, the ability of Congress to "alter what [the Court] ha[s] done" counsels strongly against altering *Pilot Life* and its progeny. *Hilton*, 502 U.S. at 202.

3. Altering The Court's Preemption Jurisprudence Would Harm Plan Participants By Reducing The Availability And Scope Of Affordable Health Insurance.

Altering ERISA preemption principles is not only unnecessary to protect plan participants, but would affirmatively harm them going forward.

It is beyond peradventure that imposing state law malpractice liability on benefit plan administrators or plan sponsors for erroneous coverage determinations would increase the cost of health plans. Such liability would (i) increase the cost of administering the health plan to the insurer or benefits

administrator, which would be passed on to employers, (ii) increase costs to employers directly where the employer administers the health plan itself, and (iii) increase administration costs due to the lack of uniformity among state law and the potential applicability of punitive damages and other remedies not available under federal law. *See* M. Langan, *ERISA Protections for Health Plans Are Weakening*, TOWERS PERRIN MONITOR (May 2003). Importantly, this increased cost would not be limited to employers who provide health benefits through HMOs or other managed care providers, because almost all health benefit plans—from those operated by HMOs to traditional fee-for-service plans—include medical necessity clauses and exclusions for experimental treatment.

Because employers are highly sensitive to cost increases in health care plans, they would quickly respond to these increasing health care costs. *See* EBRI, *supra*, at 185 (observing that in times of rising costs "virtually all employers offering health insurance coverage to their employees have taken steps to manage costs"). Specifically, employers would shift the higher costs of health benefits to employees through higher premiums, co-pays and deductibles. *See id.* ("Changes most commonly initiated by employers include imposing or increasing cost-sharing requirements."). "Another technique for controlling employer health care costs [would be] to restrict the use of certain benefits under the plan." *Id.* at 187. This could include reducing or eliminating available benefits, defining certain procedures as experimental or not necessary and thus not covered in any circumstance, or reducing the number of employees eligible for health care coverage. *See* Kaiser Study at 141. In short, subjecting benefit determinations to state-law malpractice claims would perversely cause plan sponsors to systematically restrict coverage, which is not in the interests of plan participants.

In all events, imposing such liability would reduce the number of individuals participating in health benefit plans. As employers shift costs to employees, their "health coverage

becomes increasingly burdensome and can result in some workers' inability to afford health insurance." Meyer, *supra*, at 36. As a result, "health coverage will be priced out of range for more and more working families, especially lower-paid workers, and this will only add to the numbers of uninsured and underinsured already in the system." *Id.* Alternatively, health benefit plans could become so expensive that some employers might chose to forgo providing them altogether. *See* Kaiser Study at 141 (noting that some employers reported that they were likely "to restrict employee eligibility for coverage or drop coverage entirely" in the face of rising costs). As a result, only those individuals who could afford higher-priced insurance would receive any benefit from the Court's alteration of preemption jurisprudence.

This is not an unlikely scenario but the precise result that concerned Congress when passing ERISA:

> [S]ince these plans are voluntary on the part of the employer . . . , it is necessary to take into account additional costs from the standpoint of the employer. If employers respond to more comprehensive coverage, vesting and funding rules by decreasing benefits under existing plans or slowing the rate of formation of new plans, little if anything would be gained from the standpoint of securing broader use of employee pensions and related plans.

S. Rep. No. 93-383, at 18-19 (1973), *reprinted in* 1 ERISA Leg. Hist. at 1086-87. "[Employers] do have some choice with respect to a voluntary pension plan, and while we had every desire to make it as splendid a set of protective requirements as we could, for the working people of this country, we had to be careful. If we overdid it, quite obviously we would have people writing us letters saying: 'How come you helped us so much that now we have no pension plan at all because our employer has decided he cannot afford it any longer under the new rules?'" H.R.2 Floor Debate (statement of Rep. Conable), *reprinted in* 2 ERISA Leg. Hist. at 3451.

4. The States' Interest In Regulating The Practice Of Medicine Does Not Justify A Change In Existing Preemption Principles.

Finally, there is no state interest at issue here that justifies altering the Court's ERISA preemption jurisprudence. At the petition stage, several State Attorneys General suggested that States should be allowed to impose liability on benefit plan operators that deny health care coverage due to improper medical judgment in light of the State's traditional interest in "protecting the health and welfare of its citizens." Br. of *Amici* State of Texas *et al.* at 3, in *Roark v. Humana, Inc.*, No. 02-1826 (filed Jul. 17, 2003). This argument is incorrect, because it misunderstands the nature of a benefits determination, ignores the extensive regulatory power that States currently exercise, and would so expand the regulatory authority of States as to undo any limit on liability.

The primary flaw in this argument is that it wrongly assumes coverage determinations are medical treatment decisions merely because plan administrators must sometimes reference medical standards. It is in fact common for courts to look to the medical profession to understand contracts or even statutes that contain terms that relate to a medical treatment or practice. *See* 11 WILLISTON ON CONTRACTS § 32:4 (4th ed. 1999) (discussing *Rodgers v. Rodgers*, 216 S.E.2d 322 (Ga. 1975), a case in which court looked to medical profession to interpret term "doctor" in contract). Here, too, benefits administrators look to the medical community to understand whether a recommended treatment is "medically necessary" or "experimental" within the meaning of a benefits plan. *See generally Black & Decker Disability Plan v. Nord*, 123 S. Ct. 1965, 1968 (2003) (discussing process by which benefits administrators make coverage decisions in context of holding that treating physician rule does not apply to ERISA plans). But this reference to medical custom is no more a treatment decision than a court's analysis of medical standards in interpreting a contract is a medical decision. In both instances, the reference to medical customs and standards

is part of the interpretive process, not a medical treatment decision in and of itself.

A simple example illustrates the point. In the context of organized labor, health benefit plans are typically defined through collective bargaining agreements, which can provide that an employer will pay for "medically necessary" treatments. Putting ERISA aside, if the employer and employee disagreed over whether a medical treatment was "necessary" under a collective bargaining agreement, the dispute would undoubtedly fall within the scope of § 301 of the LMRA, 29 U.S.C. § 185(a), because the dispute would relate to the interpretation of a collective bargaining agreement. Under the LMRA, the nature of the dispute would not change if the employer (or the union or, for that matter, an arbitrator or a court) consulted medical textbooks and local physicians to aid its understanding of the agreement and the so-called "law of the shop." *See Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 211 (1985). After all, the employer is not practicing medicine but making a determination about the meaning of the labor agreement. And § 301 of the LMRA requires that all "questions relating to what the parties to a labor agreement agreed, and what legal consequences were intended to flow from breaches of that agreement, must be resolved by reference to uniform federal law, whether such questions arise in the context of a suit for breach of contract or in a suit alleging liability in tort." *Id.*

Here, too, the conduct at issue does not involve a medical decision or even the provision of medical care but an interpretation of a contract, namely a health insurance contract. Moreover, like disputes over the interpretation of collective bargaining agreements, disputes over the meaning of such health benefits plans are not an area of traditional regulation by the States; on the contrary, like the LMRA and its "law of the shop," ERISA intended that the interpretation of benefits plans be a matter of exclusive federal concern. *See Pilot Life*, 481 U.S. at 54; *Metropolitan Life Ins. Co v. Taylor*, 481 U.S. at 67. Indeed, Congress specifically referenced § 301 of the LMRA

when describing ERISA's enforcement scheme, *see* H.R. Conf. Rep. No. 93-1280, at 327 (1974), *reprinted in* 3 ERISA Leg. Hist. at 4594, and this Court has held that this reference "makes clear [Congress's] intention that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions governed by § 502(a)." *Pilot Life*, 481 U.S. at 56.

In addition, this argument of state interest ignores that, under ERISA, this Court has repeatedly found preemption in areas of traditional state regulation. For example, in *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 130-31 (1992), this Court held traditional state worker's compensation laws preempted because they "impos[ed] requirements" that were not part of ERISA. *See also FMC Corp. v. Holliday*, 498 U.S. 52 (1990) (holding motor vehicle law preempted). Moreover, this Court has never hesitated to preempt state health and safety laws in favor of a uniform federal law. *See Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 546-49 (2001) (holding cigarette laws preempted); *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 103 (1992) (rejecting argument that OSHA fails to preempt state laws "designed to promote worker safety").

In all events, States can regulate in the true area of interest to them—the health and safety of their citizens—under existing jurisprudence. Most notably, States can, and do, through traditional malpractice law regulate the decisions of treating physicians, and ERISA does not preclude participants from suing a treating physician who erroneously determines that a medical treatment is not necessary. In addition, if a State believes that a certain medical treatment is important to the health of its citizens but not covered under existing contracts, it can require insurance companies to cover the treatment as part of its general authority to regulate insurance. *See* 29 U.S.C. § 1144; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746 (1985) ("If a state law 'regulates insurance,' as mandated- benefit laws do, it is not pre-empted [by ERISA].").

Finally, States can enact, and have enacted, independent utilization review statutes. *See supra* pp. 20-21.

Redefining a benefits determination to be the "practice of medicine" itself would, however, expand the authority of States in new and unacceptable ways. States, for example, could require any benefits administrator, even out-of-State administrators whose coverage determinations impact in-State plans, to adhere to state licensing requirements for medical practitioners. *See* S. Kanwit, *Should HMO Coverage Decisions Be Subject To Medical Malpractice Lawsuits? No: It Makes No Sense*, THE REGULATOR, at 12-13 (May 2003). Indeed, if administrators are subject to traditional malpractice law—as one would expect if they are "practicing medicine"—benefits administrators would have a duty to inquire about the *propriety* of care, and thus be subject to the same malpractice liabilities as treating physicians whenever they fail to exercise that judgment properly, either in denying *or* granting coverage. *Id.* But allowing States this kind of authority over plans would subject interstate benefit plans to myriad and possibly conflicting state laws. Nothing could be further from § 502's "complete preemption" purpose.

CONCLUSION

For these reasons, the decision of the court below should be reversed.

Respectfully submitted,

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